

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1995, each agency shall begin the rulemaking process by 1st filing a Notice of Proposed Rulemaking, containing the preamble and the full text of the rules, with the Secretary of State's Office. The Secretary of State shall publish the notice along with the Preamble and the full text in the next available issue of the Arizona Administrative Register.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the Register before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) ADMINISTRATION

PREAMBLE

1. **Sections Affected**

	<u>Rulemaking Action</u>
R9-22-101	Amend
R9-22-102	Amend
R9-22-712	Amend
R9-22-715	Amend
R9-22-716	Amend
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statutes: A.R.S. §§ 36-2903.01(H), 36-2903.01(J), 36-2903.01(L), 36-2904(K), 36-2908(C).

Implementing statutes: A.R.S. §§ 36-2903.01(J) and 36-2904(K)
3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name:	Cheri Tomlinson
Address:	AHCCCS, Office of Policy Analysis and Coordination 801 East Jefferson, Mail Drop 4200 Phoenix, Arizona 85034
Telephone:	(602) 417-4198
Fax:	(602) 256-6756
4. **An explanation of the rule, including the agency's reasons for initiating the rule:**

Article 1: R9-22-101 adds and clarifies definitions related to hospital reimbursement. Definitions are added for accommodation, ancillary, AHCCCS inpatient hospital day(s) of care, ancillary department, billed charges, capital costs, continuous stay, cost-to-charge ratio, encounter, ICU, Medicare crossover, medical education costs, medical review, NICU, outpatient hospital service, ownership change, prospective rate year, same day admit/discharge, and total inpatient hospital days. The definitions of the Data Resource Index, hospital, new hospital, operating cost, outlier, peer group, prospective rates, rebasing, tier, and tiered-per-diem are revised to improve their specificity. The Article 1 definitions are renumbered to reflect the additional terms.

Article 7: R9-22-712 is substantially revised to provide a more detailed description of inpatient and outpatient hospital rate-setting methods and payment practices. It should be noted that with the exception of the 2 new subsections on rebasing and direct medical education, the revisions provide clarification of the process used to calculate hospital rates effective March 1, 1993, and to calculate subsequent updates. This additional clarity is proposed in response to litigation filed against the Administration.

A new subsection is added which describes the data used in establishing reimbursement rates including both claim and encounter data and cost report data. New subsections are also added to describe the calculation of the statewide inpatient hospital cost-to-charge ratio used for payment of outliers, treatment of unassigned tiered-per-diem rates, tier assignment, the annual update of reimbursement rates, rates for new hospitals, rates in the event of an ownership change, rates for psychiatric and rehabilitation hospitals, and specialty facilities.

Two additional new subsections merit special attention, rebasing and direct medical education. Both subsections make substantive changes. The rebasing subsection implements the provisions of S.B. 1283 regarding the timeframe for rebasing. This subsection also describes the scope of rebasing and the changes to the tiered system that may occur. The direct medical education subsection

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provides the flexibility for the Administration to reimburse hospitals for medical education costs directly rather than through the tiered-per-diem rates system.

Several subsections of the rule are substantially revised to further clarify the computation of rates including: the operating component, capital component, medical education component, outliers, and outpatient hospital reimbursement.

Technical corrections only are made to subsections addressing discounts and penalties, access to records, review of claims, claims receipt, out-of-state hospital payments, and prior period payments.

Finally, subsections addressing transplants and discount and penalties, and R9-22-715 and R9-22-716, have been updated to reflect provisions of S.B. 1283. The change to R9-22-715 implements the pilot program addressed in R9-22-718 and adds flexibility to reimbursement assumptions by contractors.

5. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

6. The preliminary summary of the economic, small business, and consumer impact:

Article 1: There is no economic impact of Article 1 on small business. The impact on consumers and providers is to enhance the understanding of the rule.

Article 7: The changes to R9-22-712 do not result in changes to current rates. There is no economic impact except to the extent that adverse decisions in litigation are avoided. There is no impact on small business. The additional clarity will benefit consumers and providers making the complex hospital rate-setting methods clear.

7. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Terri Keagle

Address: AHCCCS, Office of Managed Care
701 East Jefferson, Mail Drop 8500
Phoenix, Arizona 85034

Telephone: (602) 417-4380

Fax: (602) 256-1474

8. The time, place, and nature of the proceedings for the adoption, amendment, or repeal of the rule or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: November 12, 1996

Time: 1 p.m.

Location: AHCCCS Administration
701 East Jefferson, 3rd Floor
Phoenix, Arizona

Posted signs will identify the conference room.

Nature: Public hearings on proposed rules to receive oral and written comments.

9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.

10. Incorporations by reference and their location in the rules:
Not applicable.

11. The full text of the rules follows:

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TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
ADMINISTRATION**

ARTICLE 1. DEFINITIONS

Section
R9-22-101. Definitions

ARTICLE 7. STANDARDS FOR PAYMENTS

Section
R9-22-712. Payments by the Administration for Hospital Services
R9-22-715. Hospital Rate Negotiations
R9-22-716. Specialty Contracts

ARTICLE 1. DEFINITIONS

R9-22-101. Definitions

The following words and phrases, in addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

1. "Accommodation" means those bed and board services provided to a patient during a hospital stay and includes the cost of all staffing, supplies, and equipment. The accommodation is typically semi-private except when the member must be isolated for medical reasons. Other types of accommodation include hospital routine medical/surgical units, intensive care units, and any other specialty care unit where bed and board are provided. Accommodation does not include observation.
- 1.2. "Acute mental health services" means inpatient or outpatient health services provided to treat mental or emotional disorders, as necessary for crisis stabilization, evaluation and determination of future service needs.
- 2.3. "AFDC" means Aid to Families with Dependent Children under Title IV-A of the Social Security Act, as amended.
- 3.4. "Aggregate" means the combined amount of hospital payments for covered services provided within the service area. It also applies outside the service area.
- 4.5. "AHCCCS" means the Arizona Health Care Cost Containment System which is composed of the Administration, contractors, and other arrangements through which health care services are provided to eligible persons.
- 5.6. "AHCCCS disqualified dependent" means a dependent child residing in a household with an AHCCCS disqualified spouse.
- 6.7. "AHCCCS-disqualified spouse" means the spouse of an MI/MN or state emergency services applicant, who is ineligible for AHCCCS MI/MN or state emergency services benefits because the spouse's separate property, when combined with other resources owned by all household members, exceeds the allowable resource limit.
- 7.8. "AHCCCS hearing officer" means a person designated by the Director to preside over administrative hearings regarding eligibility appeals and grievances.
9. "AHCCCS inpatient hospital day(s) of care" means the period of time beginning with the day of admission and includes each day of an inpatient stay for an eligible person, including the day of death, but excluding the day of discharge, provided that all medical necessity and medical review requirements have been met.

- 8-10. "Air ambulance" means a helicopter or fixed wing aircraft licensed under the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1, as amended, to be used in the event of an emergency to transport eligible persons to obtain services.
- 9-11. "Ambulance" means any motor vehicle licensed pursuant to the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1, especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of eligible persons requiring ambulance services.
12. "Ancillary department" means inpatient and outpatient hospital service departments, other than accommodation units, as defined by the Medicare Provider Reimbursement Manual, Chapter 28.
- 10-13. "Appeal" means a review process initiated in accordance with Article 8.
- 11-14. "Appellant" means any person or entity directly affected by an adverse action, policy or decision who initiates an appeal process.
- 12-15. "Applicant" means a person who submits, or on whose behalf is submitted, a written, signed and dated application for AHCCCS eligibility, but not for whom an eligibility determination has not been completed.
- 13-16. "Application" means an official request for AHCCCS benefits made in accordance with Article 3 of these rules.
- 14-17. "Assignment" means enrollment of an eligible person with a contractor by the AHCCCS Administration.
18. "Billed charges" means charges that a hospital includes on a claim for providing hospital services to an eligible person consistent with the rates and charges on file with the Arizona Department of Health Services.
19. "Capital costs" means hospital costs associated with building and fixtures, movable equipment, and directly assigned capital-related costs as defined by the Medicare Provider Reimbursement Manual, Chapter 28.
- 15-20. "Capped fee-for-service" means the payment mechanism by which contractors, subcontractors and other providers of care are reimbursed upon submission of valid claims for specific AHCCCS covered services and equipment provided to eligible persons. Payments will be made in accordance with an upper, or capped, limit of payment as established by the Director.
- 16-21. "Case record" means the file and all documents contained therein which are used to establish eligibility.
- 17-22. "Casualty insurance" means liability insurance coverage related to injury due to accidents or negligence.
- 18-23. "Catastrophic coverage limitation" means the financial limit as determined by the Director, beyond which the contractor is not at risk to provide or make reimbursement for treatment of illness or injury to members which results from, or is greatly aggravated by, a catastrophic occurrence or disaster including, but not limited to, natural disaster or an act of war, declared or undeclared, which occurs subsequent to enrollment.
- 19-24. "Categorically eligible" means those persons who are eligible as defined by A.R.S. § 36-2901(4)(b) or who are receiving Medicaid coverage from another state or territory.

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- 20-25. "Certification period" means the period of time for which a person is certified as eligible for AHCCCS benefits.
- 21-26. "Clean claim" means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
27. "Continuous stay" means the period of time during which the member receives inpatient hospital services without interruption beginning with the day of admission and ending with the day of discharge or death of the eligible person.
- 22-28. "Contract" means a written agreement entered into between a person, organization or other entities and the Administration to provide health care services to members under the provisions of A.R.S. Title 36, Chapter 29, and these rules.
- 23-29. "Contractor" means a person, organization or entity agreeing through a direct (prime) contracting relationship with the Administration to provide those goods and services specified by contract in conformance with the requirements of such contract and these rules.
- 24-30. "Contractor of record" means the organization or entity in which a member is enrolled for the provision of AHCCCS services.
- 25-31. "Copayment" means a monetary amount, specified by the Director, which the member pays directly to a contractor or provider at the time covered services are rendered.
32. "Cost-to-charge ratio" means a hospital's costs for providing covered services as a proportion of the hospital's covered charges for the same services.
- 26-33. "County eligibility worker" means a county employee designated to conduct eligibility interviews and determinations for AHCCCS.
34. "Covered charges" means billed charges that represent necessary, reasonable, and customary items of expense for AHCCCS covered services that meet medical review criteria of the Administration or contractor.
- 27-35. "Covered services" means those health and medical services described in Article 2 of these rules.
- 28-36. "Current residence" means the current dwelling place of the family household whether it be a house, mobile home, trailer, hogan, tent, or any shelter used as a dwelling.
- 29-37. "Data Resources Index" means the inflation factor for prospective payment published by DRI/McGraw-Hill. "DRI inflation factor" means Data Resources Inc. Health Care Financing Administration-type hospital input price index for prospective hospital reimbursement published by DRI/McGraw-Hill.
- 30-38. "Date of application" means the date on which the county eligibility office receives a completed and signed Part I of the AHCCCS application form or receives official notification from a provider of emergency services as specified in Article 3 of these rules.
- 31-39. "Date of determination" means the date on which a decision of the applicant's eligibility or ineligibility as an indigent or medically needy person, as an eligible low-income child, or as a state emergency services person is communicated by the county to the applicant by a Notice of Action and, for eligible applicants, to the Administration as specified in R9-22-334.
- 32-40. "Day" means a calendar day unless otherwise specified in the text.
- 33-41. "Deemed date of application" means the 30th day following either the original date of application or a previously deemed date of application. A deemed date of application is established for an untimely application and, for an untimely application, the deemed date shall replace the original date of application in determining the household's assets and resources and determining the household's income.
- 34-42. "Dependent child" means an unborn child or unemancipated person who is under the age of 18 or is age 18 if a full-time student in a secondary school, or in a vocational, technical, or trade school that is directly linked to the high school for which the student is receiving credits to be applied toward graduation and who is reasonably expected to complete the program before reaching age 19.
- 35-43. "DES" means the Department of Economic Security.
- 36-44. "Determination" means the process by which an applicant is approved for coverage as an indigent or medically needy person, an eligible low-income child, or a state emergency services person. Determination includes the decision by the county of an applicant's eligibility or ineligibility, the communication, for eligible applicants, of the decision by the county to the AHCCCSA Notification Unit, and the communication of the decision by the county to the applicant by a Notice of Action.
- 37-45. "Diagnostic services" means those services provided for the purpose of determining the nature and cause of a condition, illness or injury.
- 38-46. "Disenrollment" means the discontinuance of a member's entitlement to receive covered services from a specific AHCCCS contractor, and the member's name being deleted from the approved list of members furnished by the Administration to the contractor.
- 39-47. "Disqualified household member" means a person who is ineligible for indigent, medically needy, eligible low-income child, or state emergency services coverage due to a refusal to cooperate with the Title XIX eligibility process as required by state law.
- 40-48. "Eligible assistance children" means those children defined by A.R.S. § 36-2905.03(B).
- 41-49. "Eligible low-income children" means those defined by A.R.S. § 36-2905.03(C) and (D).
- 42-50. "Emancipated minor" means a person under age 18 who is married or divorced or in military service, or the subject of a court order declaring the minor to be emancipated (also see "Expressed emancipated minor").
- 43-51. "Emergency ambulance service" means:
- a. Emergency transportation by a licensed ambulance or air ambulance company or persons requiring emergency medical services.
 - b. Emergency medical services which are provided before, during or after such transportation by a certified ambulance operator or attendant.
- 44-52. "Emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
- a. Placing the patient's health in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
- 45-53. "Emergency medical services" means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including

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- severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
- a. Placing the patient's health in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
54. "Encounter" means a record submitted by a contractor and processed by AHCCCS of a medically related service rendered by a provider registered with AHCCCS to a member who is enrolled with a contractor on the date of service; including all services for which the contractor incurred any financial liability.
- 46-55. "Enrollment" means the process by which a person who has been determined eligible becomes a member of a contractor's plan under AHCCCS, pursuant to the limitations specified in these rules.
- 47-56. "E.P.S.D.T. services" means early and periodic screening, diagnosis, and treatment services for eligible persons under 21 years of age. For the purpose of these rules, the following meanings shall apply:
- a. "Early" means, in the case of a family already enrolled in AHCCCS, as early as possible in the child's life or, in other cases, as soon as a family's eligibility for AHCCCS has been established.
 - b. "Periodic" means at appropriate intervals established by the Administration for screening to assure that a condition, illness or injury is not incipient or present.
 - c. "Screening" means the use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who may have a condition, illness or injury and the identification of those in need of more definitive study. For the purposes of the AHCCCS program, screening and diagnosis are not synonymous.
 - d. "Diagnosis" means the determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests and X-rays.
 - e. "Treatment" means any type of health care or services recognized under the state Plan submitted pursuant to Title XIX of the Social Security Act to prevent or ameliorate a condition, illness or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.
- 48-57. "Equity" means the full cash or market value of a resource minus valid liens or encumbrances.
- 49-58. "Expressed emancipated minor" means a child whose parent(s) has (have) signed a notarized affidavit indicating that the child is no longer under parental support and control, and that he (they) has (have) surrendered claim to state and federal tax dependency deductions provided that the child is not living with a specified relative acting as a legal or de facto guardian and a court has not ordered custody with another person or agency.
- 50-59. "Facility" means any premise owned, leased, used, or operated directly or indirectly by or for a contractor or its affiliates for purposes related to a contract; or maintained by a provider to provide services on behalf of a contractor.
- 51-60. "Factor" means an organization, collection agency, service bureau or individual who advances money to a provider for his accounts receivable which the provider has assigned, sold or otherwise transferred, including transfer through the use of a power of attorney, to the organization or individual. The organization or individual receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. For purposes of this paragraph, the term "factor" does not include business representatives, such as billing agents or accounting firms as described within these rules, or health care institutions.
- 52-61. "Fair consideration" means money, goods or services which can be valued in terms of money that was received in exchange for property or resources transferred, and that has a value equal to at least 80% of the property or resources transferred.
- 53-62. "Federal emergency services" means emergency medical services covered under 42 CFR 440.255, March 14, 1991, incorporated by reference herein and on file with the Office of the Secretary of State, to treat an emergency medical condition for a person who is determined eligible pursuant to 42 CFR 435.406(b) and (c), March 14, 1991, incorporated by reference and on file with the Office of the Secretary of State.
- 54-63. "Full cash value" means the current value on homes and other real properties as determined by the County Assessor's Office for the county in which the real property is located.
- 55-64. "Generic drug" means the chemical or generic name, as determined by the United States Adopted Names Council (U.S.A.N.C.) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active ingredients as prescribed brand name drugs.
- 56-65. "Grievance" means a complaint arising from an adverse action, decision, or policy by a contractor, subcontractor, noncontracting provider, nonprovider, county, or the Administration, presented by a person or entity as specified by Article 8.
- 57-66. "Gross business receipts" means the total cash received from the business activity.
- 58-67. "Gross earnings from employment" means the total payment received by an employee from an employer in exchange for goods or services.
- 59-68. "Head of household" means the family household member who assumes the responsibility for providing AHCCCS eligibility information for the family household members in accordance with Article 3 of these rules.
- 60-69. "Hearing aid" means any wearable instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments or accessories of such instrument or device.
- 61-70. "High-risk pregnancy" means a pregnancy in which the mother, fetus, or newborn is or will be at increased risk for morbidity or mortality before or after delivery.
- 62-71. "Hospital" means a health care institution that which is licensed as a hospital by the Department of Health Services pursuant to A.R.S. Title 36, Chapter 4, Article 2, as a hospital, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.
72. "ICU" means the intensive care unit of a hospital.
- 63-73. "Incapacitated person" means any person who is mentally or physically impaired to the extent that he is unable to make or communicate responsible decisions concerning his person.
- 64-74. "Income in kind" means any non-cash item or service received by an individual from a person or organization.
- 65-75. "Indigent" means persons meeting income and resource criteria pursuant to A.R.S. § 11-297.
- 66-76. "Inmate of a public institution" means a person defined by 42 CFR 435.1009, May 20, 1991, incorporated by ref-

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- erence herein and on file with the Office of the Secretary of State.
- 67-77. "Interim change" means either a change occurring after the date of application and before the eligibility decision or a change occurring during the certification period.
- 68-78. "Legal guardian, conservator, executor, or public fiduciary" means a person appointed by a court or other protective order to be in charge of the affairs of a minor or incapacitated person.
- 69-79. "Legend drugs" means those drugs which under federal or state law or regulations may be dispensed only by prescription.
- 70-80. "Liquid assets" means all property and resources readily convertible to cash excluding a house or vehicle owned by a family household member.
81. "Medicare crossover" means a claim for services covered by Medicare for an eligible person with Medicare coverage.
82. "Medical education costs" means direct hospital costs for intern and resident salaries, fringes, and program costs, nursing school education, and paramedical education, as defined by the Medicare Provider Reimbursement Manual, Chapter 28.
- 71-83. "Medical equipment" means durable items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury. This definition includes, but is not limited to, such items as bedpans, hospital beds, wheelchairs, crutches, trapeze bars and oxygen equipment.
- 72-84. "Medical record" means a single, complete record kept at the site of the eligible person's primary care physician which documents the medical services received by the eligible person, including inpatient discharge summary, outpatient and emergency care.
85. "Medical review" means a review involving clinical judgement of a claim or a request for a service before or after it is paid or rendered to ensure that services provided to eligible persons are medically necessary and are covered services and that required authorizations were obtained by the provider before and while the service was rendered. The criteria for medical review is established by the Administration or contractor based on medical practice standards that are updated periodically to reflect changes in medical care.
- 73-86. "Medical services" means services pertaining to medical care that are performed at the direction of a physician, on behalf of eligible persons by physicians, dentists, nurses or other health related professional and technical personnel.
- 74-87. "Medical supplies" means consumable items which are designed specifically to meet a medical purpose.
- 75-88. "Medically necessary" means those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to:
- Prevent disease, disability and other adverse health conditions or their progression, or
 - Prolong life.
- 76-89. "Medically necessary dentures" means partial or full dentures and services that are determined to be the primary treatment of choice or an essential part of an overall treatment plan designed to alleviate a medical condition as determined by the primary care provider in consultation with the provider dentist.
- 77-90. "Medically necessary sterilization" means sterilization to:
- Prevent progression of disease, disability or adverse health conditions;
 - Prolong life and promote physical health. Sterilization for family planning is not included.
- 78-91. "Minor" means an unemancipated person who is under age 18.
- 79-92. "New hospital" means a any hospital for which Medicare Cost Report report data and claims and encounter data were not available for hospital rate development from any owner or operator of the hospital, either during either the initial prospective rate setting-setting year or for rebasing.
93. "NICU" means the neonatal intensive care unit of a hospital which has been classified as a perinatal center by the Arizona Perinatal Trust.
- 80-94. "Noncontracting provider" means a provider who has a contract or subcontract with the system and renders covered services to an eligible person for whom such provider bears no contractual obligation.
- 81-95. "Nursing facility (NF)" means an institution (or distinct part of an institution) defined by Section 1919(a) of the Social Security Act, October 1, 1990, incorporated by reference and on file with the Office of the Secretary of State.
- 82-96. "Open enrollment" means a period of time during which all currently enrolled members may select membership with another AHCCCS contractor when such choice is available.
- 83-97. "Operating costs" means allowable accommodation and ancillary hospital costs excluding capital and medical education costs.
- 84-98. "Outlier" means a hospital claim or claims encounter in which the AHCCCS inpatient hospital days of care have operating costs per day that meet the criteria described in R9-22-712 (A)(6), excluding capital and medical education, is in excess of the greater of:
- The weighted-average operating cost per day within a tier plus or minus three standard deviations.
 - The overall-weighted-average operating cost per day plus or minus two standard deviations across all tiers.
- 85-99. "Outpatient health services" means those preventive, diagnostic, rehabilitative or palliative items or services which are ordinarily provided in hospitals, clinics, physicians' offices and rural clinics, by licensed health care providers by, or under the direction of a physician or practitioner, to an outpatient.
100. "Outpatient hospital service" means a services provided in an outpatient hospital setting that does not result in an admission.
101. "Ownership change" means a change in a hospital's owner, lessor, or operator as defined in 42 CFR Section 489.18(A).
- 86-102. "Palliative services" means those services required to reduce the severity or relieve the symptoms of a condition, illness or injury.
- 87-103. "Peer group" means those hospitals that which share a common, stable, and independently definable characteristic or feature which significantly influences the cost of providing hospital services when measured statistically.
- 88-104. "Pharmaceutical services" means medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician or dentist upon referral by a pri-

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- mary care physician and dispensed in accordance with these rules.
- 89-105. "Pharmacist" means a person licensed as a pharmacist under A.R.S. Title 32, Chapter 18.
- 90-106. "Pharmacy" means an establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist and which is registered pursuant to A.R.S. Title 32, Chapter 18.
- 94-107. "Physicians' Current Procedural Terminology" (CPT) means the manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical and diagnostic services.
- 92-108. "Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law or by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
- 93-109. "Practitioner" means physicians' assistants and registered nurse practitioners who are certified and practicing in an appropriate affiliation with a primary care physician as authorized by law.
- 94-110. "Prepayment" means an arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.
- 95-111. "Prescription" means an order to a provider for covered services, which is signed or transmitted by a provider authorized to prescribe or order such services.
- 96-112. "Preventive health care" means those health care activities aimed at protection against, and early detection and minimization of, disease or disability.
- 97-113. "Prior authorization" means the process by which the Administration or contractor, whichever is applicable, authorizes in advance the delivery of covered services contingent on their medical necessity.
- 98-114. "Prospective rates" means ~~those inpatient or outpatient hospital rates defined in advance of a the payment period and representing full payment for covered services in full excluding any quick-pay discounts, slow-pay penalties, non-categorical discounts, and third-party payments regardless of billed charges or individual hospital costs.~~
115. "Prospective rate year" means ~~the period from October 1 of each year to September 30 of the following year, except for the initial prospective rate year which is between March 1, 1993, and September 30, 1994.~~
- 99-116. "Public assistance" means benefits provided to a person either directly or indirectly by a city, county, federal or state governmental agency based on financial needs.
- 100-117. "Quality management" means a methodology used by professional health personnel that assesses the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.
- 101-118. "Radiological services" means professional and technical X-ray and radioisotope services ordered by a physician or other licensed health professional for diagnosis, prevention, treatment or assessment of a medical condition. Radiological services include portable x-ray, radioisotope, medical imaging and radiation oncology.
- 102-119. "Rebasing" means the process by which, where by new Medicare Cost Report data and AHCCCS claim and encounter data are collected and analyzed to reset periodically ~~reset the inpatient hospital tiered-per-diem rates or the outpatient hospital cost-to-charge ratios.~~
- 103-120. "Referral" means the process whereby an eligible person is directed by a primary care physician to another appropriate provider or resource for diagnosis or treatment.
- 104-121. "Redetermination" means the process by which an AHCCCS member re-applies for a new eligibility certification period prior to the expiration of the current certification period.
- 105-122. "Refusal to cooperate" means that a person has refused to be interviewed by or has failed to provide information or available verification to county or DES eligibility staff or an eligibility quality control reviewer, or has refused to sign the Intent to Cooperate Form, or has failed to keep a scheduled appointment without providing a reasonable explanation or has voluntarily withdrawn from the application for federal benefits when such an application is required by state law.
- 106-123. "Rehabilitation services" means physical and respiratory therapy, audiology services, and other restorative services and items, excluding outpatient speech and occupational therapy and hearing aids for eligible persons 21 years and older, required to reduce physical disability and restore the eligible person to an optimal functional level.
- 107-124. "Residual services" means all services not covered by AHCCCS that were available to county eligible individuals through county indigent medical care programs on January 1, 1981.
- 108-125. "Retroactive coverage for medically needy, medically indigent, eligible low-income children, or state emergency services persons" means the two-day period prior to the date of determination during which AHCCCS is responsible for payment of emergency services which are not used to meet the household's spenddown liability.
109. ~~"Routine services" means those services and items included in an inpatient provider's daily room and board charge.~~
126. "Same day admit/discharge (SDAD)" means a hospital stay with the admit and discharge occurring on the same calendar day.
- 110-127. "Scope of services" means those covered, limited and excluded services set forth in Article 2 of these rules.
- 111-128. "Separate property" means real and personal property of a spouse, owned by such spouse before the marriage, or acquired by gift, devise or descent after the marriage.
- 112-129. "Service area" means the geographical area designated by the Administration within which a contractor shall provide, directly or through subcontract, covered health care services to members.
- 113-130. "Service location" means any location at which a member obtains any health care service provided by the contractor under the terms of a contract.
- 114-131. "Service site" means the location designated by the contractor at which members shall receive services from a primary care physician.
- 115-132. "Sick newborn" means an infant who is hospitalized from the date of birth and who meets one or more of the following:
- a. Had a birth weight less than 1500 grams; or
 - b. Has a deteriorating or unstabilized condition requiring admission within 72 hours of birth to a level III perinatal care center, as defined by the Arizona Peri-

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- natal Trust, Recommendations and Guidelines for Perinatal Care Centers in Arizona, 1987, incorporated by reference herein and on file with the Office of the Secretary of State; copies also are available at the central office of the AHCCCS Administration; or
- c. Has respiratory distress syndrome requiring ventilator support; or
 - d. Has significant medical problems requiring care for more than 72 hours in a level II or level III perinatal care center, as defined by the Arizona Perinatal Trust, Recommendations and Guidelines for Perinatal Care Centers in Arizona, 1987, incorporated by reference herein and on file with the Office of the Secretary of State; copies also are available at the central office of the AHCCCS Administration.
- ~~116.~~133. "S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988, incorporated by reference herein and on file with the Office of the Secretary of State.
- ~~117.~~134. "Specialist" means a Board eligible or certified physician who declares himself or herself as such and practices a specific medical specialty.
- ~~118.~~135. "Social Security Administration (SSA)" means an agency of the federal government responsible for administering certain titles of the Social Security Act, as amended.
- ~~119.~~136. "Specified relative" means a nonparent caretaker of a dependent child who is a grandmother, grandfather, sister, brother, stepmother, stepfather, aunt, uncle, first cousin, niece, nephew, or person of preceding generations. A specified relative must be 18 or over to apply on behalf of a dependent child, unless awarded custody by a court.
- ~~120.~~137. "Spend down" means the dollar value of incurred medical expenses that the family household must have in order to bring their net annual income within the eligibility income limit.
- ~~121.~~138. "Spouse" means the husband or wife of an AHCCCS applicant or household member, who has entered into a contract of marriage, recognized as valid by the state of Arizona.
- ~~122.~~139. "State emergency services" means emergency medical services to treat an emergency medical condition, which services are covered under R9-22-217 for a person who is determined eligible pursuant to A.R.S. § 36-2905.05.
- ~~123.~~140. "Subcontract" means an agreement entered into by a contractor with any of the following:
- a. A provider of health care services who agrees to furnish covered services to members.
 - b. A marketing organization.
 - c. Any other organization or person who agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligations to the Administration under the terms of a contract.
- ~~124.~~141. "SSI" means Supplemental Security Income under Title XVI of the Social Security Act, as amended.
- ~~125.~~142. "Third party" means any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member.
- ~~126.~~143. "Tier" means a grouping of inpatient hospital services into levels of care based on diagnosis, procedure, and revenue codes, peer group, and NICU classification level, or any combination thereof.
- ~~127.~~144. "Tiered-per-diem" means a payment structure in which payment is made on a per-day basis depending upon the tier into which ~~a day falls an AHCCCS inpatient hospital day of care is assigned.~~
- ~~128.~~145. "Third party liability" means the resources available from a person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or eligible person.
- ~~146.~~ "Total inpatient hospital days" means the total number of days, including all hospital subprovider and nursery days from the Medicare Cost Report for all payors. Observation days and swing beds are not included.
- ~~129.~~147. "Untimely application" means an MI/MN application for which the date of determination is later than the 30th day following the date of application or, if the head of the household has agreed in writing to an extension, later than the 60th day following the date of application. For MI/MN-S.O.B.R.A. dual applications, when the completed application has been submitted to DES within 30 days after the date of application but DES has not determined S.O.B.R.A. eligibility within 30 days after the date of application, the application for those household members for whom S.O.B.R.A. eligibility is being determined is not an untimely application if the date of determination is not later than the tenth working day after a determination of S.O.B.R.A. eligibility has been made by DES or the 20th working day after the application was forwarded to DES, whichever is earlier.
- ~~130.~~148. "Utilization control" means the overall accountability program encompassing quality management and utilization review.
- ~~131.~~149. "Utilization review" means a methodology used by professional health personnel that assesses the medical indications, appropriateness and efficiency of care provided.
- ~~132.~~150. "Work-related expenses" means non-reimbursed expenses related to employment for travel, meals, lodging, uniforms, licenses for employment, union dues, tools, or material required for employment.

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-712. Payments by the Administration for Hospital Services

- A. Inpatient hospital reimbursement. ~~Payment by the The~~ Administration ~~shall pay~~ for covered inpatient acute care hospital services, provided to eligible persons with admissions on and after March 1, 1993, ~~shall be made on a prospective reimbursement basis. The Prospective prospective rates shall represent payment in full, excluding quick-pay discounts, slow-pay penalties, non-categorical discounts, and third-party payments for both accommodation routine and ancillary services. The rates shall include reimbursement for operating, capital, and medical education costs, as applicable. The Administration shall classify Each each AHCCCS inpatient hospital day of care a hospital stay shall be classified into one of several tier tiers appropriate to the services rendered for payment purposes. This The rate for a particular tier is referred to as the tiered-per-diem rate of reimbursement. Until the time of rebasing, as described in this Section, the number of tiers is 7 and the maximum number of tiers payable per continuous stay~~

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is 2. Payment of outlier or transplant claims or payment to out-of-state hospitals, freestanding psychiatric hospitals, rehabilitation hospitals, and other specialty facilities may differ from the inpatient hospital tiered-per-diem rates of reimbursement described in this Section.

1. Tier rate data. To calculate the tiered-per-diem rates for the initial prospective year, the Administration shall use Medicare Cost Reports for Arizona hospitals for fiscal years ending in 1990 and a data base consisting of inpatient hospital claims and encounters for each hospital with beginning dates of service for the period November 1, 1990, through October 31, 1991.

a. Medicare Cost Report data. Because Medicare Cost Report years are not standard among hospitals and were not audited at the time of the rate calculation for the initial prospective rate year, the Administration shall inflate all the costs to a common point in time as described in subsection (A)(2) for each component of the tiered-per-diem rates. The Administration shall not make any changes to the tiered-per-diem rates if the Medicare Cost Report data are subsequently updated or adjusted. If a single Medicare Cost Report is filed for more than 1 hospital, the Administration shall allocate the costs to each of the respective hospitals. Hospitals shall submit information to assist the Administration in this allocation.

b. Claim and encounter data. For the data base, the Administration shall use only those inpatient hospital claims paid by the Administration and encounters that were accepted and processed by the Administration at the time the data base was developed pursuant to A.R.S. § 36-2903.01(I). The Administration shall subject the claim and encounter data to a series of data quality, reasonableness, and integrity edits and shall exclude claims and encounters that fail these edits from the data base. The Administration may make adjustments to the data as required to correct errors. The Administration shall also exclude from the data base the following claims and encounters:

- i. Those missing information necessary for the rate calculation.
- ii. Medicare crossovers.
- iii. Those submitted by freestanding psychiatric hospitals, and
- iv. Those for transplant services or any other hospital service that the Administration would pay on a basis other than the tiered-per-diem rate.

1-2. Tier rate components. The Administration shall establish the Component of prospective tiered-per-diem methodology rates that are paid to hospitals including the following 3 components rates: operating, capital, and medical education. Hospitals shall receive payment representing reimbursement for operating, capital and medical education costs as follows: The rate for the operating component shall be a statewide rate for each tier except for the ICU tier which is based on peer groups. The rate for the medical education component shall be hospital-specific. The rate for the capital component shall be a blend of statewide and hospital-specific values based upon a sliding scale until October 1, 2002. The Administration shall not include the medical education component in the tiered-per-diem rates if direct medical education payments are made pursuant to subsection (A)(12). The Administration shall use the following methodologies to establish the rates for each of these components and to

calculate the statewide inpatient cost-to-charge ratio used for payment of outliers and out-of-state hospitals.

a. Operating component. Using the Medicare Cost Reports and the claim and encounter data base, the rate for the operating component shall be computed as follows:

i. Data preparation. The Administration shall identify and group into department categories, the Medicare Cost Report data that provide ancillary cost-to-charge ratios and accommodation costs per day. To comply with the federal regulation 42 CFR 447.271, the Administration shall limit cost-to-charge ratios at 1.00 for each ancillary department.

ii. Operating cost calculation. To calculate the rate for the operating component, the Administration shall derive the operating costs from claims and encounters by combining the Medicare Cost Report data and the claim and encounter data base for each hospital. In performing this calculation, the Administration shall match the revenue codes on the claims and encounters to the departments in which the line items on the Medicare Cost Reports have been grouped. The ancillary department cost-to-charge ratios for a particular hospital shall be multiplied by the covered ancillary charges on each of the hospital's claims and encounters. The AHCCCS inpatient days of care on the particular hospital's claims and encounters shall be multiplied by the corresponding accommodation costs per day from the hospital's Medicare Cost Report. The ancillary cost-to-charge ratios and accommodation costs per day shall exclude medical education and capital costs. The Administration shall inflate the resulting costs for the claims and encounters to a common point in time, December 31, 1991, using the DRI inflation factor and shall reduce all the costs by an audit adjustment factor equal to 4 %.

iii. Operating cost tier assignment. The Administration shall then assign the resulting costed claims and encounters to tiers based on diagnosis, procedure, and revenue codes, and NICU classification level, or a combination thereof. For the ICU tier, claims and encounters shall be further assigned to the urban or rural peer group. The tier rate for NICU Level II shall be calculated as 75% of the NICU Level III tier rate. For claims and encounters assigned to more than 1 tier, ancillary costs shall be allocated to the tiers in the same proportion as the accommodation costs. Before calculating the rate for the operating component of the tiered-per-diem rates, the Administration shall identify and exclude any claims and encounters that are outliers as defined in subsection (A)(6).

i. Establishing reimbursement rates.

iv. Operating rate calculation. The Rates rates for the operating component for each tier shall be set by dividing total statewide or peer group hospital costs identified in this subsection within the tier by the total number of days AHCCCS inpatient hospital days of care reflected in the claim and encounter data base

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- for that tier, within the tier. This calculation shall be performed differently for statewide and peer-grouped rates. When the tiered-per-diem rate is statewide, the calculation shall be based on all of the costs and all of the days within the state. When the rate is peer-grouped, the calculation shall be performed separately, based on all of the costs and all of the days within each peer group.
- ii. ~~Updating rates. Between rebasing years, tiered-per-diem rates shall be annually inflated by the Data Resources Incorporated market basket index for prospective payment system hospitals and adjusted for changes in length of stay in accordance with A.R.S. § 36-2903.01(J)(2) and (3).~~
 - iii. ~~New hospitals shall receive the tiered-per-diem rates as established in subparagraph (i).~~
- b. ~~Medical education component.~~
- i. ~~Establishing reimbursement rates. Computation of medical education costs and component rate. (1) Hospitals shall receive payment to compensate for costs associated with advanced medical education training programs. Payments shall be The Administration shall calculate the rate for the medical education component of the tiered-per-diem rate set on a hospital-specific basis, based on the daily costs for by identifying the total direct medical education costs listed on the hospital's Medicare Cost Report. The medical education costs identified shall reflect the costs incurred by all the payors for hospital services, including AHCCCS. The Administration shall reduce the medical education costs by an audit adjustment factor equal to 4%. The reduced medical education costs shall be divided by the hospital's total inpatient days for all patients to yield the rate for the medical education component of the tiered-per-diem rate.~~
 - ii. ~~Indexing medical education component to tiers. (2) Actual medical education add-on payments shall be indexed. The Administration shall index the rate for the medical education component for to each tier by a the relative weight weighting factor of that tier's operating component to the operating component of the other tiers. The relative weighting factor is shall be calculated by dividing each of the hospital's tier rate for the operating rates component by the weighted average of all the tier operating component rates for that hospital. The Administration shall determine the weighted average by first weighting each hospital's tier operating component rate by the proportion of AHCCCS inpatient days of care for the tier to the hospital's total AHCCCS inpatient days of care reflected in the claim and encounter data base and then calculating the average rate for the operating component across all the tiers for that hospital.~~
 - ii. ~~Updating rates. Between years in which the reimbursement system is rebased, medical education add-on payments shall be inflated forward by the Data Resources Index.~~
 - iii. ~~New hospitals medical education programs.~~
- shall not receive medical education payments between rebasing years. The tiered-per-diem rates for hospitals with new medical education programs that are not reflected on the Medicare Cost Reports used to establish rates pursuant to this Section shall not include a medical education component until the Medicare Cost Reports used in rebasing reflect the costs of the new medical education programs or, at the discretion of the Director, until a component is approved. The prospective tiered-per-diem rates that are paid to these hospitals shall be the sum of the component rates for operating and capital. If a hospital already has an existing medical education program that is reflected in their Medicare Cost Report but has added a new medical education program which is not reflected, the hospital's tiered-per-diem rates shall include a component rate for medical education that only reflects those medical education costs included in the Medicare Cost Report.
- c. ~~Capital component.~~
- i. ~~Establishing reimbursement rates. Structure of the capital cost component. (1) Hospitals shall receive payment to compensate for capital costs associated with treating eligible persons. After a ten-year phase-in, the capital component shall be combined with the operating component. During the phase-in 10-year period beginning with the initial prospective rate year, the rate for the capital reimbursement component of the tiered-per-diem rate shall represent a blend of statewide and individual hospital capital costs in accordance with A.R.S. § 36-2903.01(J)(9). After September 30, 2002, the Administration shall combine the rate for the capital component with the rate for the operating component to produce a single statewide component rate for capital and operating.~~
 - ii. ~~Computation of statewide capital costs and component rate. The capital costs associated with inpatient hospital care for each hospital shall be calculated in a manner similar to that described for operating costs in subsection (A)(2)(a)(ii). The costs associated with ancillary department cost-to-charge ratios and the accommodation costs per day that include only operating costs and medical education costs, shall be subtracted from the costs associated with ancillary and accommodation costs per day that include capital costs as well as operating costs and medical education costs. The Administration shall inflate the resulting capital costs for each hospital to December 31, 1991, using the DRI inflation factor and shall reduce the capital costs by an audit adjustment factor equal to 4%. The statewide per day rate for capital shall be calculated by dividing the resulting total capital costs by the total AHCCCS inpatient hospital days of care reflected in the claim and encounter data base.~~
 - iii. ~~Computation of hospital-specific capital. The Administration shall calculate the hospital-specific capital costs per day for each hospital by dividing the capital costs identified for each~~

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hospital in subsection (A)(2)(c)(ii), as adjusted by the audit factor and inflated to December 31, 1991, by the AHCCCS inpatient hospital days of care for that hospital reflected in the claim and encounter database.

- iv. Blending of capital rates. The Administration shall set the rate for the capital component by blending of the statewide and hospital-specific capital rates in accordance with the following schedule:

PROSPECTIVE RATE YEAR	HOSPITAL SPECIFIC	STATEWIDE
3/1/93 - 9/30/94	90%	10%
10/1/94 - 9/30/95	80%	20%
10/1/95 - 9/30/96	70%	30%
10/1/96 - 9/30/97	60%	40%
10/1/97 - 9/30/98	50%	50%
10/1/98 - 9/30/99	40%	60%
10/1/99 - 9/30/00	30%	70%
10/1/00 - 9/30/01	20%	80%
10/1/01 - 9/30/02	10%	90%
10/1/02 - 9/30/03	0%	100%

Because the rate for the capital component is a blend of the statewide and hospital-specific costs, the capital component shall not be further inflated to the mid-point of the initial prospective rate year.

- (2) Actual v. Indexing capital component to tiers. The Administration shall index the rate for the capital payments shall be indexed component for to each tier by a the relative weight weighting factor of that tier's operating component to the operating component of the other tiers. The relative weight weighting factor is shall be calculated by dividing each of the hospital's tier rate for the operating component rates by the weighted average of all the tier operating component rates for that hospital and as further described in subsection (A)(2)(b)(ii).
- ii. Updating rates. During the ten-year phase-in period, and between years in which the reimbursement system is rebased, capital payment shall be updated as follows:
- (1) ~~The statewide portion of the capital payment shall be inflated by the Data Resources Index.~~
 - (2) ~~The hospital-specific part of the payment shall be revised using updated capital costs from the hospital's Medicare Cost Report. The percentage change in capital costs per day shown on the Medicare Cost Report from one year to the next shall be applied to the hospital-specific portion of the capital payment.~~
- iii. New hospitals. Capital reimbursement for new hospitals shall be equal to the average capital cost per day and indexed according to statewide relative weights per tier.
2. Stop-loss-stop-gain mechanism. Until September 30, 1996, a stop-loss-stop-gain mechanism defines a reimbursement floor and ceiling.
- a. ~~The Administration shall identify hospitals in which payment levels for particular tiers would reimburse below the floor established in A.R.S. § 36-2903.01(J)(1). Tiered-per-diem rates shall then be reset at the floor level provided that there are at least~~

b. ~~The Administration shall identify hospitals in which payment levels for particular tiers would reimburse above the ceiling established in A.R.S. § 36-2903.01(J)(1). Tiered-per-diem rates shall then be reset at the ceiling level provided that there are at least 25 cases for that hospital in the rate-setting database for the tier.~~

d. Statewide inpatient hospital cost-to-charge ratio. The Administration shall calculate the AHCCCS statewide inpatient hospital cost-to-charge ratio for payment of outliers, pursuant to subsection (A)(6), by using the Medicare Cost Report data and claim and encounter data base described in subsection (A)(1) and used to determine the initial tiered-per-diem rates. For each hospital, the covered accommodation days on the claims and encounters shall be multiplied by the corresponding accommodation costs per day from the Medicare Cost Report. For each hospital, the covered ancillary charges on the claims and encounters shall be multiplied by the ancillary cost-to-charge ratios. The accommodation costs per day and the ancillary cost-to-charge ratios for each hospital shall be determined in the same way as described in subsection (A)(2)(a) but shall include costs for operating, capital and medical education. The Administration shall then calculate the statewide inpatient hospital cost-to-charge ratio by summing the covered accommodation and ancillary costs from the claims and encounters for all hospitals and dividing by the sum of the total covered charges for all hospitals.

e. Unassigned tiered-per-diem rates. In the case of a hospital for which no tiered-per-diem rate is assigned to a tier, the Administration shall pay the statewide rate for the operating component of that tier if the hospital has qualifying claims and encounters subsequent to the base year. The rates for the capital and medical education components of a tiered-per-diem rate, if applicable, shall be re-weighted for a tier to which no tiered-per-diem rate is assigned as described in subsections (A)(2)(b) and (A)(2)(c).

3. Tier assignment. The Administration shall assign AHCCCS inpatient hospital days of care to tiers based on information submitted on the inpatient hospital claim or encounter including diagnosis, procedure and revenue codes, peer group, and NICU classification level or a combination thereof.

a. Tier hierarchy. Assignment of AHCCCS inpatient hospital days of care to a tier shall follow an ordered, hierarchical processing, as defined on the Hierarchy for Tier Assignment, which is included in subsection (I). Claims for inpatient hospital services must meet medical review criteria and the definition of a clean claim. The Administration shall not pay for a hospital stay on the basis of more than 2 tiers, regardless of the number of interim claims that are submitted by the hospital. If a hospital changes its designation under Medicare from a rural to an urban hospital, or visa versa, the Administration shall continue to assign claims from that hospital to the rural ICU tiered-per-diem rate, or visa versa, until such time that the tiered-per-diem rates are rebased.

b. Tier exclusions. The Administration shall not assign or pay AHCCCS inpatient hospital days of care that do not occur during an individual's eligibility

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period. Except in the case of death, the Administration shall pay claims in which the day of admission and the day of discharge are the same, termed a same day admit and discharge, including same day transfers, as an outpatient hospital claim. Same day admit and discharge claims that qualify for either the maternity or nursery tiers shall be paid based on the lesser of the rate for the maternity or nursery tier, or the outpatient hospital cost-to-charge ratio times ancillary and accommodation charges.

c. Seven tiers. The following 7 tiers shall be in effect until the time of rebasing:

- i. Maternity. The maternity tier shall be identified by a primary diagnosis code. If a claim has an appropriate primary diagnosis, the AHCCCS inpatient hospital days of care on the claim shall be paid the maternity tiered-per-diem rate.
- ii. NICU. The NICU tier shall be identified by a revenue code. For a hospital to qualify for the NICU tiered-per-diem rate, the hospital must be classified as either a NICU Level II or NICU Level III perinatal center by the Arizona Perinatal Trust. All of the days on the claim with the NICU revenue code that meet medical review criteria for NICU shall be paid at the NICU tiered-per-diem rate for that hospital. Any remaining day or days on the claim not meeting NICU Level II or NICU Level III medical review criteria shall be paid at the nursery tiered-per-diem rate.
- iii. ICU. The ICU tier shall be identified by a revenue code. If there are AHCCCS inpatient hospital days of care on the claim that meet the criteria for the ICU tier, days with an ICU revenue code shall be paid at the ICU tiered-per-diem rate. If there are days on the claim without an ICU revenue code, they may be classified as surgery, psychiatric, or routine tiers.
- iv. Surgery. The surgery tier shall be identified by a revenue code in combination with a valid surgical procedure code that is not on the AHCCCS excluded surgical procedure list. The excluded surgical procedure list shall identify minor procedures such as sutures that do not require the same hospital resources as other procedures. A surgery claim may also have AHCCCS inpatient hospital days of care at the ICU tier. AHCCCS shall pay the surgery tier only when the surgery occurs on a date during which the member is eligible.
- v. Psychiatric. The psychiatric tier shall be identified by either: a psychiatric revenue code and a psychiatric diagnosis or any routine revenue code if all diagnosis codes on the claim are psychiatric. A claim with AHCCCS inpatient hospital days of care in the psychiatric tier may split only with the ICU tier.
- vi. Nursery. The nursery tier rate shall be identified by a revenue code. A claim with AHCCCS inpatient hospital days of care in the nursery tier may split only with the NICU tier.
- vii. Routine. The routine tier shall be identified by particular revenue codes and shall include days that are not otherwise classified into the preceding tiers or paid in accordance with subsec-

tion (A)(11). The routine tier may split only with the ICU tier.

4. Annual update. After the initial prospective rate year and between rebasing years, the Administration shall annually update the inpatient hospital tiered-per-diem rates in accordance with A.R.S. § 36-2903.01(I)(2) and A.R.S. § 36-2903.01(I)(9) as follows:

- a. Inflation factor. The rates for the operating and medical education components of the tiered-per-diem rate shall be inflated to the midpoint of the prospective rate year, using the DRI inflation factor.
- b. Length of stay adjustment. The rate for the operating component of the tiered-per-diem rate shall be adjusted for any change in the statewide average length of stay for eligible persons. The change in length of stay shall be computed each year by comparing the average length of stay for each tier based on claims and encounters to the average length of stay for each tier calculated in the previous year. The operating component of the tiered-per-diem tier rates shall be adjusted by the percentage change in length of stay. If the length of stay increases for a tier, the rate for the operating component shall be adjusted downward. If the length of stay decreases for a tier, the rate for the operating component shall be adjusted upward. Except for the first annual update of the initial prospective rate year, the Administration shall use claims and encounters that are from the federal fiscal year period beginning 2 years before the prospective rate year that is being updated. For the annual update for the prospective rate year beginning October 1, 1996, the claims and encounters with beginning dates of service from October 1, 1994 to September 30, 1995 shall be used for making any length of stay adjustment. For the annual update of the initial prospective rate year, the Administration shall use claims and encounters with beginning dates of service from March 1, 1993 to September 30, 1993. The Administration shall subject the claim and encounter data to the same data edits described in subsection (A)(1)(b). Outliers shall be excluded as identified in subsection (A)(6)(b).
- c. Capital component update. For the capital component of the tiered-per-diem rate, the Administration shall adjust the hospital-specific and statewide average blend described in subsection (A)(2)(c). The Administration shall adjust the hospital-specific part of the capital component by using the capital costs from the hospital's subsequent Medicare Cost Report. The Medicare Cost Report used for the first update is FY1991. The percentage change in the capital costs per day, as shown on the hospital's Medicare Cost Report from 1 year to the next, shall be applied to the hospital-specific part of the capital component rate. The Administration shall recalculate the statewide average part of the capital component rate based on the percentage change in hospital-specific capital costs. The percentage change shall be limited to the initial prospective rate year statewide capital costs increased by the DRI inflation factor. The Administration shall adjust the rate for the capital component of the tiered-per-diem downward, if after the update, the statewide average capital component rate as a percent of the statewide average total tiered-per-diem rate exceeds the per-

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centage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered-per-diem rates for the initial prospective rate year.

5. New Hospitals. The Administration shall calculate the tiered-per-diem rates for new hospitals differently than the tiered-per-diem rates for hospitals in which Medicare Cost Reports and claims and encounters were used to establish the tiered-per-diem rates for the initial prospective rate year or for a rebase year. The tiered-per-diem rates paid to new hospitals shall be the sum of the operating and capital components. The operating component rate for a new hospital shall be the same as the operating component rate established in subsection (A)(2)(a). The capital component rate for a new hospital shall represent the statewide average capital rate as described in subsection (A)(2)(c)(ii) and shall vary by tier based on an index that represents the statewide relative weight of that tier's operating component to the operating component of the other tiers. The tiered-per-diem rates for new hospitals shall not include a medical education component. The annual update shall be applied to a new hospital's component rates for operating and capital, except hospital-specific capital costs shall not be considered as described in subsection (A)(2)(c)(iii).
- 3-6. Outliers. The Administration shall reimburse hospitals for AHCCCS inpatient hospital days of care identified as outliers in accordance with this Section by multiplying the covered allowable charges on the claim by times the statewide inpatient hospital cost-to-charge ratio.
 - a. Outlier criteria. For the initial prospective rate year, the Administration shall set the statewide outlier cost threshold for each tier at the greater of 3 or more standard deviations from the statewide mean operating cost per day within the tier, or 2 or more standard deviations from the statewide mean operating cost per day across all the tiers. The Administration shall set hospital-specific charge thresholds by dividing the statewide outlier cost threshold for each tier by the hospital's inpatient operating cost-to-charge ratio. If the covered charges per day on a claim or encounter exceeds the hospital-specific charge threshold for a tier, the claim or encounter shall be considered an outlier. If there are 2 tiers on a claim or encounter, the Administration shall determine if the claim or encounter is an outlier by using a weighted threshold for the 2 tiers.
 - b. Update. The Administration shall update the outlier threshold annually by recalculating the standard deviations based on the claims and encounters described in subsection (A)(4)(b). The Administration shall estimate the cost of claims and encounters based on the application of an inpatient hospital-specific operating cost-to-charge ratio.
- 4-7. Transplants. The Administration shall reimburse hospitals for an AHCCCS acute-care inpatient stay in which a covered organ transplant is was performed either through the terms of a relevant contract agreement, ~~or~~ in the absence of a contract, at the AHCCCS statewide inpatient cost-to-charge ratio multiplied by allowed charges (billed charges that represent covered services and are medically necessary). If the Administration and a hospital that performs a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.

8. Rebasing. The Administration shall rebase the tiered-per-diem rates by the prospective rate year beginning October 1, 1998. The rebasing process shall include the following:
 - a. Rebasing data. The Administration shall use the hospitals' Medicare Cost Reports for fiscal years ending at least 2 years before the prospective rate year in which the rebase is to begin. For example, for the rebase year of October 1, 1998, the Medicare Cost Reports would be for hospital fiscal years ending in 1996, or earlier. In addition for each hospital, the Administration shall use a data base consisting of selected inpatient hospital claims and, if appropriate, selected encounters with beginning dates of service covered by their hospital's respective Medicare Cost Reporting periods. Claims and encounters will be selected based on the data available at the time of rebasing that passes the Administration's data quality, reasonableness, and integrity edits. For the Medicare Cost Report data, the Administration shall follow the procedures described in subsection (A)(1)(a), except that costs shall be inflated to December of the fiscal year for which the Medicare Cost Reports are taken and a new audit factor shall be derived by the Administration which shall be based on available national and Arizona data. To calculate the rebased tiered-per-diem rates, the Administration may use ancillary departments or line items from the Medicare Cost Report at the time of rebasing. For the data base, the Administration shall use selected claims and encounters that have been accepted and processed by the Administration before the time the data base is developed for rebasing the tiered-per-diem rates. The Administration shall subject the Medicare Cost Reports and the claim and encounter data to the same basic data edits described in subsection (A)(1)(b). The Administration shall exclude or adjust the claims or encounters that do not meet medical review criteria pursuant to R9-22-717 and R9-22-209(C).
 - b. Rebasing components. The rebased tiered-per-diem rates shall continue to include the following 2 component rates: operating and capital. The Medical education component shall be included unless direct medical education is reimbursed pursuant to subsection (A)(12). The Administration shall follow the basic methodology that is described in subsection (A)(2) in establishing the new rebased rates for each of the components. However, during the rebasing process the Administration shall re-examine the current tier structure and may adopt an alternative structure, hierarchy, or number of tiers based on the statistical analyses conducted by the Administration. The Administration shall add cost containment features at the time of rebasing.
 - c. Rebasing peer groups for the operating component. To rebase the rate for the operating component of the tiered-per-diem rate, the Administration shall re-analyze whether the operating component shall be peer grouped according to such factors as geographical location or major teaching versus non-major teaching hospital.
 - d. Rebasing the capital component. For rebasing that occurs for or after the prospective rate year, October 1, 1998, the rate for the capital component of the tiered-per-diem rate shall be a blend of statewide

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and hospital-specific capital costs pursuant to subsection (A)(2)(c). The Administration shall adjust the rate for the capital component of the tiered-per-diem rate downward if the after rebasing the statewide average capital component rate as a percent of the statewide average total tiered-per-diem rate exceeds the percentage of the statewide average capital costs to the total statewide average inpatient hospital costs used in calculating the tiered-per-diem rates for the initial prospective rate year or the most recently available national average percentage of capital costs to total inpatient hospital costs. The downward adjustment shall be based on the higher percentage.

- e. Rebasing outliers. The Administration may not include provisions for payment of outliers at the time of rebasing.
 - f. Psychiatric and rehabilitation hospitals. At the time of rebasing, the Administration shall re-examine the basis of payment for freestanding rehabilitation and psychiatric hospitals. If the decision is made to continue to reimburse these hospitals according to the methodology described in subsection (A)(10), the Administration shall exclude the claims and encounters from these hospitals that are not paid by the tiered-per-diem reimbursement system.
 - g. Data required. Beginning with fiscal years ending in 1996, hospitals shall file with the Administration all Medicaid-specific schedules of the Medicare Cost Report at the time the Medicare Cost Report is submitted to the Medicare Intermediary as required in A.R.S. § 36-125.04.
9. Ownership change. A hospital shall not receive a change in any of the components of the hospital's tiered-per-diem rates upon an ownership change.
10. Psychiatric and rehabilitation hospitals. The Administration shall pay freestanding psychiatric hospitals an all-inclusive per diem rate based on the contracted rates used by the Arizona Department of Health Services and shall pay freestanding rehabilitation hospitals the rate for the operating component of the routine tiered-per-diem rate plus capital and medical education component rates as appropriate or an all-inclusive per diem rate that is negotiated by the Administration.
11. Specialty facilities. The Administration may negotiate, at any time, reimbursement rates for inpatient specialty facilities or inpatient hospital services not otherwise addressed in this Section pursuant to A.R.S. § 2903.01(I)(1).
12. Direct medical education payments. Instead of including a direct medical education component in the tiered-per-diem rates, the Administration may reimburse hospitals directly for the hospital's costs associated with direct medical education. For this purpose, the Administration may continue to calculate direct medical education costs using the methodology described in subsection (A)(2)(b)(i). Direct medical education payments may not be updated pursuant to Subsection (A)(4).
- B. Outpatient hospital reimbursement. Payment by the The Administration shall pay for covered outpatient acute-care hospital services provided to eligible persons on and after March 1, 1993, shall be made at the AHCCCS hospital-specific outpatient hospital cost-to-charge ratio, multiplied by the allowed covered charges. (billed charges that represent covered services and are medically necessary);

1. Establishing reimbursement rates. Computation of outpatient hospital reimbursement. The Administration shall compute the A cost-to-charge ratio is computed for each hospital on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each on a hospital-specific basis. Outpatient operating and capital costs shall be included in the computation but outpatient Medical medical education costs are excluded from the computation because both inpatient and outpatient medical education costs are reimbursed through that are included in the inpatient medical education component shall be excluded. To calculate the outpatient hospital cost-to-charge ratio for the initial prospective rate year for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a data base consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in subsections (A)(1)(a) and (A)(1)(b). The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:
 - a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters for outpatient hospital services. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
 - b. Cost-to-charge limit. To comply with the federal regulation (42 CFR 447.325), the Administration shall limit cost-to-charge ratios at 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse New new hospitals shall be reimbursed at the weighted AHCCCS statewide average outpatient hospital cost-to-charge ratio multiplied by covered allowed charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for new hospitals until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing. (billed charges that represent covered services and are medically necessary-)
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in specialty facilities.
- 3-4. Reimbursement requirements. For a hospital to receive payment from the Administration, the submitted claim shall be legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse Hospitals hospitals shall not be reimbursed for emergency room treatment, or observation hours, or other

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outpatient hospital services performed on an outpatient basis if the eligible person is subsequently admitted on the same day as an inpatient to the same hospital. The Administration shall pay only the appropriate inpatient tiered-per-diem rate for an eligible person who is admitted following through the emergency room treatment, observation, or other outpatient hospital services.

5 Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every 1 to 4 years using updated Medicare Cost Reports and claims and encounters data.

- C. Discounts and penalties. Payment by the The Administration for shall subject all inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, shall be subject to quick-pay discounts and slow-pay penalties in accordance with Laws 1993, Chapter 6, § 29; Laws 1992, Chapter 302, § 14, as amended by Laws 1993, Chapter 6, § 27; Laws 1992, Ch. 302, §14, as amended by Laws 1993, 2nd S.S., Ch. 6, § 27; Laws 1995, 1st S.S., Ch. 5, § 6 and A.R.S. § 36-2903.01(J)(6).
- D. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall not withhold access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or its designated representative in performance of the Administration's utilization control activities. Failure to cooperate may result in denial or non-payment of claims.
- E. Prior authorization. Failure to obtain prior authorization required by R9-22-210 shall be cause for denial or nonpayment of claims.
- F. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may shall subject all hospital claims, to include including outlier outliers claims, are subject to prepayment medical review, and or post-payment review or both by the Administration. Post-payment reviews shall be consistent with A.R.S. § 36-2903.01(O) and erroneously paid claims are subject to recoupment. If prior authorization was given for a specific level of care but medical

review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more most appropriate level of care, such adjustment to which shall be effective on the date when the different level of care was medically appropriate.

- G. Claim receipt. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim was received by the Administration as indicated by the date stamp on the claim and the claim reference number. Hospital claims will be considered paid on the date indicated on disbursement checks. Denied claims will be considered adjudicated on the date of their denial. Claims that are denied and are resubmitted will receive new date stamps. Claims that are pending for additional supporting documentation from hospitals will receive new date stamps upon receipt of the additional documentation, except as provided under R9-22-717. Claims that pend for additional supporting documentation shall not be counted in the calculation of the quick-pay discounts and slow-pay penalties pursuant to R9-22-712(C). Timeframes for submittal of claims and the definition of clean claim, for purposes of this subsection, shall be consistent with A.R.S. § 36-2904.
- H. Out-of-state hospital payments. Payment by the The Administration shall pay for covered hospital services provided to eligible persons by out-of-state hospitals shall be made at negotiated discounted rates, the Arizona statewide average inpatient or outpatient cost-to-charge ratio multiplied by covered allowed charges or, if reasonably and promptly available, the Medicaid rate that is in effect at the time services are provided in the state in which the hospital is located, whichever is lowest.
- I. Prior period payments. Payments by the The Administration shall pay for covered hospital services, provided to eligible persons with inpatient hospital admissions and outpatient hospital services prior to before March 1, 1993, shall be made pursuant to R9-22-706.
- J. Hierarchy For Tier Assignment.

TABLE: HIERARCHY FOR TIER ASSIGNMENT

TIER	IDENTIFICATION CRITERIA	ALLOWED SPLITS
MATERNITY	A primary diagnosis defined as maternity 640.xx-643.xx, 644.2x-676.xx, v22.xx - v24.xx or v27.xx.	None
NICU	Revenue Code 174 AND the provider has a Level II or III NICU.	Nursery
ICU	Revenue Codes of 200-204, 207-212, or 219.	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of 36x. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list.	ICU

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PSYCHIATRIC	Psychiatric Revenue Codes of 114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx. If a routine revenue code is present and all diagnoses codes on the claim are equal to 290.xx-316.xx, classify as a psychiatric claim.	ICU
NURSERY	Revenue Code of 17X. Not equal to 174 unless the provider does not have a Level II or III Perinatal Center.	NICU
ROUTINE	Revenue Codes of 100 - 101, 110-113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16x, 206, 213, or 214.	ICU

R9-22-715. Hospital Rate Negotiations

A. Effective for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, contractors that negotiate with hospitals for inpatient or outpatient services shall reimburse hospitals for member care based on the prospective tiered-per-diem amount or the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by allowed charges set forth in A.R.S. § 36-2903.01 and R9-22-712 or at the negotiated rate that, when considered in the aggregate with other hospital reimbursement levels, does not exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712. Health Plans participating in the pilot program pursuant to R9-22-718 are not subject to this requirement.

1. Contractors may engage in rate negotiations with hospitals at any time during the contract period.
2. Within ~~7~~ seven days of the completion of the agreement process, contractors shall submit copies of their negotiated rate agreements, to include all rates, terms, and conditions, with hospitals to the Administration for approval. Contractors shall demonstrate to the Administration that the effect of their negotiated rate agreement will, when considered in the aggregate, be the same as or will produce greater dollar savings than what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712.

a. To demonstrate the aggregate effect of its negotiated rate agreement, contractors shall present their assumptions related to projected utilization of various hospitals to the Administration. The contractor may consider inpatient assumptions related to:

- i. ~~member~~ Member mix;
- ii. ~~admissions~~ Admissions by AHCCCS-specified tiers;
- iii. ~~average~~ Average length of stay by tier and pattern of admissions, excluding emergency admissions; and
- iv. ~~outliers~~ Outliers; and
- v. Risk-sharing arrangements. The contractor also may consider outpatient assumptions related to member mix and outpatient service utilization. The Administration reserves the right to approve, deny, or require mutually-agreed-to modifications to these assumptions. ~~Failure to obtain Administration approval will limit the contractor to only using the prospective tiered-per-diem systems set forth in A.R.S. § 36-2903.01 and R9-22-712.~~

b. When contractors adjust or modify their assump-

tions, the reason for the adjustment or modification shall be included, as well as the new assumptions. Any changes in assumptions is ~~are~~ subject to approval, denial, or mutually-agreed-to modifications by the Administration.

- c. To determine ~~whether~~ if the negotiated rate agreement produced reimbursement levels that did not in the aggregate exceed what would have been paid pursuant to A.R.S. § 36-2903.01 and R9-22-712, contractors shall require their independent auditors to evaluate the reasonableness of their assumptions as part of the annual audit. The independent auditor's audit program shall be consistent with AHCCCS audit requirements and shall be prior approved by the Administration.
- d. Negotiated inpatient or outpatient rate agreements with hospitals ~~where with which~~ a contractors has have a related party interest are subject to additional related party disclosure and evaluation. ~~These~~ Such evaluations are in addition to the procedures described ~~above in subsection (A)(2)(c)~~ and shall be performed by the contractor's independent auditors, or, at the contractor's ~~its~~ option, additional evaluations may be performed by the Administration.
- e. The Administration may subject a the contractors' independent auditor's report to any ~~such~~ examination or review necessary to ensure accuracy of any or all findings related to aggregate rate determinations.
- f. The Administration shall use its standards, consistent with the Request for Proposals and R9-22-502, to determine ~~if the whether~~ a contractor's inpatient or outpatient hospital subcontracts ~~will would~~ limit the availability or accessibility of services. The Administration reserves the right to reject hospital subcontracts that limit a the member's availability or accessibility of services.

B. The Administration may negotiate or contract with hospitals on behalf of contractors for discounted hospital rates. ~~and may require that the Negotiated negotiated discounted rates may be required to be included in contracts between contractors and hospitals.~~

C. The Director shall apportion any cost avoidance in the hospital component of provider capitation rates between the Administration and provider. The Administration's portion of the cost avoidance shall be reflected in reduced capitation rates paid to providers.

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R9-22-716. Specialty Contracts

The Director may at any time negotiate or contract on behalf of providers, noncontracting providers, and the Administration for specialized hospital and medical services. ~~Such services may include including, but are not limited to, neonatology, neurology, cardiology, and burn care. If the Director has contracted contracts for such specialized services, contractors of record may be required to include the such services within their delivery networks and make contractual modifications necessary to carry out this Section. Specialty contractors shall take precedence over all other contractual arrangements between contractors of record and their subcontractors. Specialty contractors may require interim payments to specialty contractors on behalf of contractors of record for contract~~

~~services received by members. Interim Such payments to specialty contractors may be deducted from capitation payments, performance bonds, or other like monies for payment on behalf of contractors of record. Effective for inpatient hospital admissions and outpatient hospital services that begin on or after March 1, 1993, should the Director not negotiate or contract on behalf of providers, noncontracting providers and the Administration for transplant services, contractors of record shall use the payment rate pursuant to R9-22-712(A)(4). If the Administration and a hospital that performed a transplant surgery on an eligible person do not have a contracted rate, the system shall not reimburse the hospital more than the contracted rate established by the Administration.~~